STANLEY J. MORRIS, D.M.D.

DIPLOMATE OF THE AMERICAN BOARD OF ORTHODONTICS
Specialist in Orthodontics and Oro-Facial Orthopedics for Adults and Children

20 Greenwood Lake Turnpike
Ringwood, NJ 07456

(973) 835-9393 office
(973) 835-6636 fax

PATIENT INFORMATION

Name: _____ Date of Birth: ____/____/____
Last First MI

Nickname: _____ Age: _____ Sex: _____ Height: _____ Weight: _____

Home Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____ E-mail address: _____

Sports/Hobbies/Interests: _____

School: _____ Grade: _____

Siblings: Sisters (#): _____ Ages: _____ Brothers (#): _____ Ages: _____

RESPONSIBLE PARTY INFORMATION

Mother's Name: _____ Date of Birth: ____/____/____
Last First MI

Home Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____ E-mail address: _____

Social Security #: _____/_____/_____ Occupation: _____ Firm Name: _____

Father's Name: _____ Date of Birth: ____/____/____
Last First MI

Home Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____ E-mail address: _____

Social Security #: _____/_____/_____ Occupation: _____ Firm Name: _____

MEDICAL HISTORY

Physician's Name: _____ Office Phone:_____

Address: _____
Street City State Zip Code

Has the patient ever had any of the following problems?	Yes	No
Unhealthy infancy, Breast or Formula feeding difficulty	□	□
Indigestion, nausea, vomiting, jaundice, night fever	□	□
Diarrhea – constipation – abdominal cramps	□	□
Bone fractures – any major accidents – epilepsy	□	□
Change in weight recently – poor appetite – fainting	□	□
Hayfever – asthma – eczema – hives – anemia	□	□
Excessive bleeding – black and blue tendency	□	□
Growths – tumors – unusual swellings – diabetes	□	□
Blood in stool or urine, kidney, or bladder condition	□	□
Rheumatic – Scarlet fever	□	□
Cancer – chemotherapy	□	□
Heart condition – heart murmur – Mitral valve prolapse	□	□
Psychiatric Problems	□	□
Severe headaches – Shingles	□	□
Has patient reached puberty	□	□
Has patient had any blood transfusions	□	□
Has patient acquired immune deficiency (AIDS) – Hepatitis	□	□

Is the patient currently under a physician's care? Y N
If yes, please explain:

_____

Is the patient currently taking any medications? Y N
If yes, please explain:

_____

Does the patient have any allergies? Y N
If yes, please explain:

_____

Has the patient ever been hospitalized for any reason? Y N
If yes, please explain:

_____

Signature of Responsible Party _____ Date ____/____/____

DENTAL HISTORY

Dentist's Name: _____ Office Phone:_____

Address: _____
Street City State Zip Code

Has the patient ever had any of the following problems?	Yes	No
Started teeth very early or late	□	□
Baby teeth removed that were not loose	□	□
Chipped or otherwise injured baby or permanent teeth	□	□
Permanent or "Extra" (supernumerary) teeth removed	□	□
Presently have extra or missing teeth	□	□
Teeth sensitive to hot or cold. Teeth throb or ache	□	□
Jaw fractures – cysts – abscess – other infections	□	□
"Dead teeth" – Root canals treated	□	□
Bleeding gums – bad taste – mouth odor	□	□
Gingivitis – "Vincents" infection – "Pockets"	□	□
Food impaction between teeth – periodontal problems	□	□
"Gum Boils" – frequent canker sores – "cold sores"	□	□
Lip, cheek, tongue-biting, soreness, or bleeding	□	□
Any wisdom tooth problem	□	□
Finger-thumb sucking habit until age _____	□	□
Abnormal swallowing habit (tongue thrust) until age _____	□	□
Nail biting habit or Mouth breathing habit	□	□
Tooth grinding – jaw clenching-clicking, locking, pain	□	□
Difficulty encountered in breathing, chewing	□	□
Aware of loose, broken, or missing fillings	□	□
Any teeth irritating cheek – lip – tongue – palate	□	□
Concerned about spaced – crooked – or protruding teeth	□	□
Aware or concerned about under or over-developed jaw	□	□
Any relative with similar tooth or jaw relationship	□	□
Any paid or clicking near the ears If yes, Right □ Left □	□	□
Any periodontal treatment of had a gingivectony	□	□

ORTHODONTIC HISTORY

	Yes	No
Has the patient ever had orthodontic treatment or worn a retainer or bite plate?	□	□
Have you consulted another orthodontist?	□	□
Any family member(s) currently under orthodontic treatment?	□	□

What are the patient's (or parent's) primary concerns? (why are you here?) _____

_____

DENTAL INSURANCE

Name of Insured _____ Relationship to patient _____

Birthdate ____/____/____ Social Security #: _____/_____/_____ Date Employed _____/_____/_____

Name of Employer _____ Union/Local # _____ Work Phone _____

Address of Employer _____
Street City State Zip Code

Insurance Company _____ Group/Policy/ID # _____

Insurance Co. Address _____
Street City State Zip Code

Lifetime Maximum _____ How much have you used? _____ Deductible _____

Do you have any additional dental insurance? □ Yes □ No If yes, complete the following:

Name of Insured _____ Relationship to patient _____

Birthdate ____/____/____ Social Security #: _____/_____/_____ Date Employed _____/_____/_____

Name of Employer _____ Union/Local # _____ Work Phone _____

Address of Employer _____
Street City State Zip Code

Insurance Company _____ Group/Policy/ID # _____

Insurance Co. Address _____
Street City State Zip Code

Lifetime Maximum _____ How much have you used? _____ Deductible _____

I hereby certify that the above information is true and correct to the best of my knowledge. I understand that it is my responsibility to inform the office of any changes. I also understand that I am ultimately responsible for payment for all services rendered to myself or my dependents.

Signature _____ Date ____/____/____
(Even if you are uninsured, please sign to signify that you have seen the page and have no dental insurance)